



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

UNIVERSITY OF MICHIGAN

68714663

0070051870004 - 05FCV

Effective Date: 01/01/2017

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility Information

Members

Eligibility Criteria

Dependents

- Subscriber's legal spouse or same gender domestic partner eligible for coverage under the subscriber's contract
- Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same gender domestic partner; eligible for coverage through the last day of the month the dependent turns age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits

In-network

Out-of-network

Deductible

None

None

Flat-dollar copays

- \$20 copay for office visits and office consultations
- \$20 copay for chiropractic and osteopathic manipulative therapy
- \$20 copay for outpatient physical, speech and occupational therapy for professional services
- \$75 copay for emergency room visits

- \$75 copay for emergency room visits

Coinsurance amounts (percent copays)

- 50% of approved amount for private duty nursing care

- 50% of approved amount for private duty nursing care
- 50% of approved amount for mental health care and substance abuse treatment
- 50% of approved amount for most other covered services

Note: Coinsurance amounts apply once the deductible has been met.

Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable

\$3,000 for one member
\$6,000 for the family (when two or more members are covered under your contract) each calendar year

\$5,000 for one member
\$10,000 for the family (when two or more members are covered under your contract) each calendar year

Lifetime dollar maximum

None

Preventive care services

Benefits

In-network

Out-of-network

Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures

100% (no deductible or copay/coinsurance), one per member per calendar year

Not covered

Note: Additional well-women visits may be allowed based on medical necessity

Gynecological exam

100% (no deductible or copay/coinsurance), one per member per calendar year

Not covered

Note: Additional well-women visits may be allowed based on medical necessity.

Pap smear screening - laboratory and pathology services

100% (no deductible or copay/coinsurance), one per member per calendar year

Not covered

Voluntary Sterilization for Females

100% (no deductible or copay/coinsurance)

50% (no deductible)

Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician

100% (no deductible or copay/coinsurance)

100% (no deductible or copay/coinsurance)

Contraceptive injections

100% (no deductible or copay/coinsurance)

50% (no deductible)

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	50% (no deductible) Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	50% (no deductible)

One per member per calendar year

One per member per calendar year

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	50% (no deductible)
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	50% (no deductible)
Office consultations - must be medically necessary	\$20 copay per office consultation	50% (no deductible)
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	50% (no deductible)

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$75 copay per visit (copay waived if admitted or for an accidental injury)	\$75 copay per visit (copay waived if admitted or for an accidental injury)

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% (no deductible or copay/coinsurance)	50% (no deductible)
Diagnostic tests and x-rays	100% (no deductible or copay/coinsurance)	50% (no deductible)
Therapeutic radiology	100% (no deductible or copay/coinsurance)	50% (no deductible)

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	50% (no deductible)
Postnatal care visit	100% (no deductible or copay/coinsurance)	50% (no deductible)
Delivery and nursery care	100% (no deductible or copay/coinsurance)	50% (no deductible)

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% (no deductible or copay/coinsurance)	50% (no deductible)
Note: Nonemergency services must be rendered in a participating hospital.		Unlimited days
Inpatient consultations	100% (no deductible or copay/coinsurance)	50% (no deductible)
Chemotherapy	100% (no deductible or copay/coinsurance)	50% (no deductible)

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
		Limited to a maximum of 120 days per member per calendar year.
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
		Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care: • must be medically necessary • must be provided by a participating home health care agency	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Home Health Aide - when provided by the University of Michigan medical students for members who are C5 level quadriplegic	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor 	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% (no deductible or copay/coinsurance)	50% (no deductible)
Presurgical consultations	100% (no deductible or copay/coinsurance)	50% (no deductible)
Voluntary sterilization for males	100% (no deductible or copay/coinsurance)	50% (no deductible)
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary Abortions	100% (no deductible or copay/coinsurance)	50% (no deductible)

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	50% (no deductible)
Specified oncology clinical trials	100% (no deductible or copay/coinsurance)	50% (no deductible)
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% (no deductible or copay/coinsurance)	50% (no deductible)

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health or substance abuse service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance abuse treatment	100% (no deductible or copay/coinsurance)	50% (no deductible)
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria 	100% (no deductible or copay/coinsurance)	50% (no deductible)
Outpatient mental health care: <ul style="list-style-type: none"> • Facility and clinic 	\$20 copay per office visit	50% (no deductible or copay/coinsurance) in participating facilities only

Benefits	In-network	Out-of-network
Physician's office	\$20 copay per office visit	50% (no deductible)
Outpatient substance abuse treatment - in approved facilities only	\$20 copay per office visit	50% (no deductible) (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% (no deductible or copay/coinsurance)	50% (no deductible)
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	50% (no deductible)

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> 100% (no deductible or copay/coinsurance) for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	50% (no deductible)
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	50% (no deductible)
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit Limited to a combined 24-visit maximum per member per calendar year	50% (no deductible)
Outpatient physical, speech and occupational therapy - provided for rehabilitation	<ul style="list-style-type: none"> Professional services: \$20 copay per visit Facility services: 100% (no deductible or copay/coinsurance) Limited to a combined 60-visit maximum per member per calendar year	50% (no deductible)
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Diagnosis and Treatment of infertility Limited to lifetime maximum of \$20,000 Note: Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine. Note: Additional restrictions apply	80% (no deductible)	Not covered
Testing procedures for Infertility	100% (no deductible/coinsurance)	50% after out-of-network deductible
Routine eye examination - one per member, per calendar year	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) up to an annual maximum of \$40 per service
Nutritional counseling when performed to treat the following conditions: anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified	100% (no deductible or copay/coinsurance)	50% (no deductible)
Prescription drugs	Not covered	Not covered

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Hearing Care Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.